



General Assembly

January Session, 2007

Substitute Bill No. 7055

* _____HB07055INS__030207_____*

AN ACT CONCERNING MEDICAL NECESSITY AND EXTERNAL APPEALS.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

1 Section 1. (NEW) (*Effective October 1, 2007*) (a) No insurer, health
2 care center, hospital and medical service corporation or other entity
3 delivering, issuing for delivery, renewing, continuing or amending any
4 individual health insurance policy in this state on or after October 1,
5 2007, shall deliver or issue for delivery in this state any such policy
6 unless such policy contains a definition of "medically necessary" or
7 "medical necessity" as follows: "Medically necessary" or "medical
8 necessity" means health care services that a physician, exercising
9 prudent clinical judgment, would provide to a patient for the purpose
10 of preventing, evaluating, diagnosing or treating an illness, injury,
11 disease or its symptoms, and that are: (1) In accordance with generally
12 accepted standards of medical practice; (2) clinically appropriate, in
13 terms of type, frequency, extent, site and duration and considered
14 effective for the patient's illness, injury or disease; and (3) not primarily
15 for the convenience of the patient, physician or other health care
16 provider and not more costly than an alternative service or sequence of
17 services at least as likely to produce equivalent therapeutic or
18 diagnostic results as to the diagnosis or treatment of that patient's
19 illness, injury or disease. For the purposes of this subsection, "generally
20 accepted standards of medical practice" means standards that are

21 based on credible scientific evidence published in peer-reviewed
22 medical literature generally recognized by the relevant medical
23 community or otherwise consistent with the standards set forth in
24 policy issues involving clinical judgment.

25 (b) The provisions of subsection (a) of this section shall not apply to
26 any insurer, health care center, hospital and medical service
27 corporation or other entity that has entered into any national
28 settlement agreement until the expiration of any such agreement.

29 Sec. 2. (NEW) (*Effective October 1, 2007*) (a) No insurer, health care
30 center, hospital and medical service corporation or other entity
31 delivering, issuing for delivery, renewing, continuing or amending any
32 group health insurance policy in this state on or after October 1, 2007,
33 shall deliver or issue for delivery in this state any such policy unless
34 such policy contains a definition of "medically necessary" or "medical
35 necessity" as follows: "Medically necessary" or "medical necessity"
36 means health care services that a physician, exercising prudent clinical
37 judgment, would provide to a patient for the purpose of preventing,
38 evaluating, diagnosing or treating an illness, injury, disease or its
39 symptoms, and that are: (1) In accordance with generally accepted
40 standards of medical practice; (2) clinically appropriate, in terms of
41 type, frequency, extent, site and duration and considered effective for
42 the patient's illness, injury or disease; and (3) not primarily for the
43 convenience of the patient, physician or other health care provider and
44 not more costly than an alternative service or sequence of services at
45 least as likely to produce equivalent therapeutic or diagnostic results
46 as to the diagnosis or treatment of that patient's illness, injury or
47 disease. For the purposes of this subsection, "generally accepted
48 standards of medical practice" means standards that are based on
49 credible scientific evidence published in peer-reviewed medical
50 literature generally recognized by the relevant medical community or
51 otherwise consistent with the standards set forth in policy issues
52 involving clinical judgment.

53 (b) The provisions of subsection (a) of this section shall not apply to

54 any insurer, health care center, hospital and medical service
55 corporation or other entity that has entered into any national
56 settlement agreement until the expiration of any such agreement.

57 Sec. 3. Section 38a-478n of the general statutes is repealed and the
58 following is substituted in lieu thereof (*Effective from passage*):

59 (a) Any enrollee, or any provider acting on behalf of an enrollee
60 with the enrollee's consent, who has exhausted the internal
61 mechanisms provided by a managed care organization, health insurer
62 or utilization review company to appeal the denial of a claim based on
63 medical necessity or a determination not to certify an admission,
64 service, procedure or extension of stay, regardless of whether such
65 determination was made before, during or after the admission, service,
66 procedure or extension of stay, may appeal such denial or
67 determination to the commissioner. As used in this section and section
68 38a-478m, "health insurer" means any entity, other than a managed
69 care organization, which delivers, issues for delivery, renews or
70 amends an individual or group health plan in this state, "health plan"
71 means a plan of health insurance providing coverage of the type
72 specified in subdivision (1), (2), (4), (10), (11), (12) and (13) of section
73 38a-469, but does not include a managed care plan offered by a
74 managed care organization, and "enrollee" means a person who has
75 contracted for or who participates in a managed care plan or health
76 plan for himself or his eligible dependents.

77 (b) (1) To appeal a denial or determination pursuant to this section
78 an enrollee or any provider acting on behalf of an enrollee shall, not
79 later than [thirty] sixty days after receiving final written notice of the
80 denial or determination from the enrollee's managed care organization,
81 health insurer or utilization review company, file a written request
82 with the commissioner. The appeal shall be on forms prescribed by the
83 commissioner and shall include the filing fee set forth in subdivision
84 (2) of this subsection and a general release executed by the enrollee for
85 all medical records pertinent to the appeal. The managed care
86 organization, health insurer or utilization review company named in

87 the appeal shall also pay to the commissioner the filing fee set forth in
88 subdivision (2) of this subsection. If the Insurance Commissioner
89 receives three or more appeals of denials or determinations by the
90 same managed care organization or utilization review company with
91 respect to the same procedural or diagnostic coding, the Insurance
92 Commissioner may, on said commissioner's own motion, issue an
93 order specifying how such managed care organization or utilization
94 review company shall make determinations about such procedural or
95 diagnostic coding.

96 (2) The filing fee shall be twenty-five dollars and shall be deposited
97 in the Insurance Fund established in section 38a-52a. If the
98 commissioner finds that an enrollee is indigent or unable to pay the
99 fee, the commissioner shall waive the enrollee's fee. The commissioner
100 shall refund any paid filing fee to (A) the managed care organization,
101 health insurer or utilization review company if the appeal is not
102 accepted for full review, or (B) the prevailing party upon completion of
103 a full review pursuant to this section.

104 (3) Upon receipt of the appeal together with the executed release
105 and appropriate fee, the commissioner shall assign the appeal for
106 review to an entity as defined in subsection (c) of this section.

107 (4) Upon receipt of the request for appeal from the commissioner,
108 the entity conducting the appeal shall conduct a preliminary review of
109 the appeal and accept the appeal if such entity determines: (A) The
110 individual was or is an enrollee of the managed care organization or
111 health insurer; (B) the benefit or service that is the subject of the
112 complaint or appeal reasonably appears to be a covered service, benefit
113 or service under the agreement provided by contract to the enrollee;
114 (C) the enrollee has exhausted all internal appeal mechanisms
115 provided; (D) the enrollee has provided all information required by the
116 commissioner to make a preliminary determination including the
117 appeal form, a copy of the final decision of denial and a fully-executed
118 release to obtain any necessary medical records from the managed care
119 organization or health insurer and any other relevant provider.

120 (5) Upon completion of the preliminary review, the entity
121 conducting such review shall immediately notify the member or
122 provider, as applicable, in writing as to whether the appeal has been
123 accepted for full review and, if not so accepted, the reasons why the
124 appeal was not accepted for full review.

125 (6) If accepted for full review, the entity shall conduct such review
126 in accordance with the regulations adopted by the commissioner, after
127 consultation with the Commissioner of Public Health, in accordance
128 with the provisions of chapter 54.

129 (c) To provide for such appeal the Insurance Commissioner, after
130 consultation with the Commissioner of Public Health, shall engage
131 impartial health entities to provide for medical review under the
132 provisions of this section. Such review entities shall include (1) medical
133 peer review organizations, (2) independent utilization review
134 companies, provided any such organizations or companies are not
135 related to or associated with any managed care organization or health
136 insurer, and (3) nationally recognized health experts or institutions
137 approved by the commissioner.

138 (d) (1) Not later than five business days after receiving a written
139 request from the commissioner, enrollee or any provider acting on
140 behalf of an enrollee with the enrollee's consent, a managed care
141 organization or health insurer whose enrollee is the subject of an
142 appeal shall provide to the commissioner, enrollee or any provider
143 acting on behalf of an enrollee with the enrollee's consent, written
144 verification of whether the enrollee's plan is fully insured, self-funded,
145 or otherwise funded. If the plan is a fully insured plan or a self-insured
146 governmental plan, the managed care organization or health insurer
147 shall send: (A) Written certification to the commissioner or reviewing
148 entity, as determined by the commissioner, that the benefit or service
149 subject to the appeal is a covered benefit or service; (B) a copy of the
150 entire policy or contract between the enrollee and the managed care
151 organization or health insurer, except that with respect to a self-
152 insured governmental plan, (i) the managed care organization or

153 health insurer shall notify the plan sponsor, and (ii) the plan sponsor
154 shall send, or require the managed care organization or health insurer
155 to send, such copy; or (C) written certification that the policy or
156 contract is accessible to the review entity electronically and clear and
157 simple instructions on how to electronically access the policy or
158 contract.

159 (2) Failure of the managed care organization or health insurer to
160 provide information or notify the plan sponsor in accordance with
161 subdivision (1) of this subsection within said five-business-day period
162 or before the expiration of the [thirty-day] sixty-day period for appeals
163 set forth in subdivision (1) of subsection (b) of this section, whichever
164 is later as determined by the commissioner, shall (A) create a
165 presumption on the review entity, solely for purposes of accepting an
166 appeal and conducting the review pursuant to subdivision (4) of
167 subsection (b) of this section, that the benefit or service is a covered
168 benefit under the applicable policy or contract, except that such
169 presumption shall not be construed as creating or authorizing benefits
170 or services in excess of those that are provided for in the enrollee's
171 policy or contract, and (B) entitle the commissioner to require the
172 managed care organization or health insurer from whom the enrollee
173 is appealing a medical necessity determination to reimburse the
174 department for the expenses related to the appeal, including, but not
175 limited to, expenses incurred by the review entity.

176 (e) The commissioner shall accept the decision of the review entity
177 and the decision of the commissioner shall be binding.

178 (f) Not later than January 1, 2000, the Insurance Commissioner shall
179 develop a comprehensive public education outreach program to
180 educate health insurance consumers of the existence of the appeals
181 procedure established in this section. The program shall maximize
182 public information concerning the appeals procedure and shall
183 include, but not be limited to: (1) The dissemination of information
184 through mass media, interactive approaches and written materials; (2)
185 involvement of community-based organizations in developing

186 messages and in devising and implementing education strategies; and
187 (3) periodic evaluations of the effectiveness of educational efforts. The
188 Healthcare Advocate shall coordinate the outreach program and
189 oversee the education process.

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>October 1, 2007</i>	New section
Sec. 2	<i>October 1, 2007</i>	New section
Sec. 3	<i>from passage</i>	38a-478n

INS *Joint Favorable Subst.*